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ABSTRACT

With widespread implementation of mainstreaming in Manitoba, regular classroom teachers need diagnostic information to plan modified programs for special needs students. This report describes the demand for and availability of diagnostic services for special needs students in Agro-Manitoba, which comprises 34 rural school divisions in the province's agricultural area. A literature review examines use of formal versus informal assessment, stages in the referral process, and recent developments in reading diagnosis. A survey was developed and mailed to all special education administrators in Agro-Manitoba. Responses were received from 26 of the 34 school divisions. The survey covered the availability of various clinical services, consultant services, and community services that provide diagnostic information; sharing of services with other school divisions; new programs or practices to improve services; the location of services; details of the referral process; types of problems referred to the province's Diagnostic Support Centre (DSC), DSC services to districts, and related costs; and suggested changes. Interviews were also carried out at the DSC and at the Child Care and Development Branch of the provincial department of education. Results indicate that many rural divisions are sharing services; large caseloads and long waits for services are problems; and some school divisions need increased school support staff. Recommendations are offered based on survey results and comparisons with expert opinions on essential services. Appendices include the survey questionnaire, interview schedules, and a glossary. Contains 36 references, and 9 tables of data. (SV)

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A DESCRIPTIVE ANALYSIS OF DIAGNOSTIC SERVICES FOR SPECIAL NEEDS STUDENTS IN AGRO-MANITOBA

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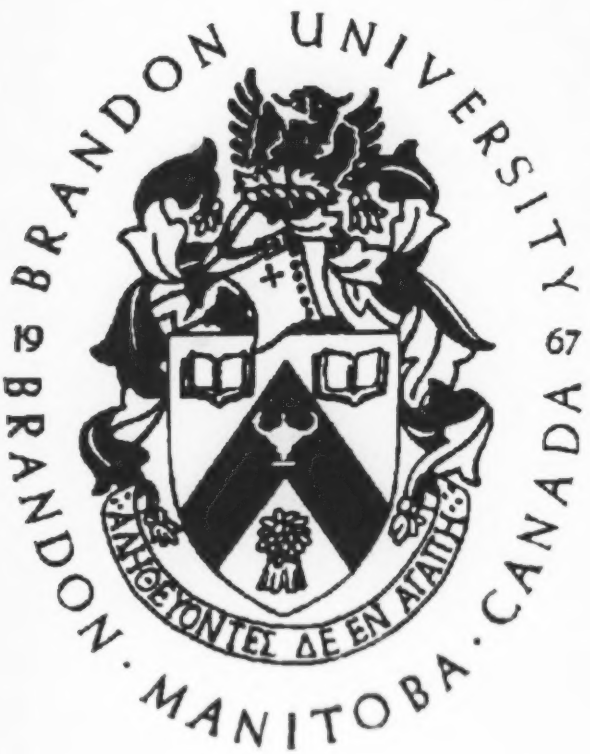

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A Descriptive Analysis of Diagnostic Services for Special Needs Students in Agro-Manitoba

by

Robin Bradshaw

M.Ed., Brandon University

The Rural Development Institute
Brandon University

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PREFACE

The Rural Development Institute is pleased to initiate publication of the Rural Education Research series with this report. In 1991, Manitoba Education and Training, Manitoba Rural Development and The Rural Development Institute at Brandon University announced the Graduate Research in Rural Education program. This cooperative program was designed to 1) provide a framework for focusing on educational issues related to rural Manitoba, 2) provide assistance to graduate students who intend to study rural education, and 3) provide the Department of Education and Training with information for addressing education issues within the broader context of rural development.

To ensure that information is distributed widely, RDI retains the option of publishing results after theses have been approved. In this manner, rural education is placed on the local and provincial agendas for debate, and citizens have access to information which may affect programs for their children. Development of the human resources of rural Manitoba remains the most significant endeavour in rural development.

We thank Robin Bradshaw for her efforts to complete this report for publication by RDI. Joan Rollheiser, Administrative Assistant at RDI, prepared the document for publication. Dr. John Didyk of Manitoba Education and Training, and Marie Elliott of Manitoba Rural Development assisted in the program. Drs. Dale Hayes and Jack Deines of the Faculty of Education at Brandon University, served as faculty advisors.

Dr. R. C. Rounds, Series Editor,
Director, RDI

ABSTRACT

This study provides a descriptive analysis of diagnostic services for special needs students in Agro-Manitoba. Three aspects are 1) to determine demand for and availability of diagnostic services, 2) to contrast what is currently available with those services viewed as necessary by leading experts in the field of diagnosis in special education, and 3) based upon delineation of essential services to make recommendations for improvement of services and improved availability of those services in Agro-Manitoba. A literature review examined three important diagnosis/assessment issues: 1) use of formal or informal assessment methods, 2) the referral process, and 3) reading diagnosis pertaining to special education.

The research was organized into five stages. First, a pilot study was used to collect information about current diagnostic practices. Derived information allowed design of a survey instrument. Second, the survey was mailed to the Special Education Administrators in the 34 school divisions that comprise Agro-Manitoba. Both quantitative and qualitative data were provided by the survey. The third stage consisted of data analysis. Stage four, an interview at the Child Care and Development Branch, provided information about current practices and plans for the future. The final stage involved an interview at the (Manitoba) Diagnostic Support Centre to obtain information about facilities, programs, and students who are referred.

Results of the survey indicate that many rural divisions are sharing diagnostic/assessment services. Large caseloads and long waits for services are considered problems. The survey also suggests that some school divisions need increased school support staff, including psychologists, speech/language pathologists, social workers, reading clinicians, and occupational and physiotherapists.

Diagnostic information often is used to make funding decisions. Agro-Manitoba school divisions are providing basic diagnostic/assessment services for special needs students. Recommended changes are based on contrasting the status of diagnostic services in Agro-Manitoba with services that are considered essential by experts in special education. Recommendations concerning the Diagnostic Support Centre and further research and professional practices are presented.

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INTRODUCTION

This report provides an overview of the status of diagnostic services for special needs students in Agro-Manitoba. It describes and explains the variety of practices available to meet the needs of special education students. Agro-Manitoba is defined as the thirty-four school divisions situated in the agricultural area of the Province. Manitoba school divisions not included are located in Metropolitan Winnipeg and in northern Manitoba.

The need for diagnostic services has increased because of widespread implementation of mainstreaming in special education in the Province of Manitoba. Greater numbers of regular classroom teachers need diagnostic information to plan modified programs and Individualized Education Plans (IEP) for mainstreamed special needs students. Also, a need exists for effective access to diagnostic services and frequent monitoring of programs to determine their effectiveness. Varying levels of diagnostic services are available in all divisions, with some divisions sharing services, but there is a need for a comprehensive description of the type, location, and availability of these services.

Thirty-four school divisions comprise Agro-Manitoba, with a (1990) total enrolment of 74,454 students in 384 schools (Rounds, 1991). The provincial government provides most of the funding for education in Agro-Manitoba. However, this funding decreased from 76.1 percent in 1983 to 71.7 percent in 1987 (Rounds, 1991). As a result, funding from municipalities increased from 18.8 percent to 23.5 percent during that time. It was found that the ratio between municipal and provincial funding varied by as much as 15 percent among rural divisions. One division in Agro-Manitoba identified funding as a problem in their Annual Division Action Plan (ADAP). They indicated that "the funding now available through provincial grants is inadequate," because teachers and parents expect more from school divisions in the areas of special needs identification and program planning. "The costs have become the increasing responsibility of the [local division]. More of the financial burden must be assumed by the province".

Bowman (1981) studied the effects of depopulation in rural Manitoba, and increasing per pupil costs was identified as an area of concern. Many rural school divisions continued to experience declining enrolments since Bowman's study was completed. It is anticipated that rural depopulation will continue and school enrolments in most rural divisions will decline slowly (MacLean and Rounds, 1991).

Concern herein is focused on methods that rural divisions use to cope with increased demands for special education services when educational costs are increasing. The services available were assessed by a survey administered to all the divisions in Agro-Manitoba. Other agencies, such as Health and Family Services, are partners in the delivery of special needs services and were included in the survey.

Mainstreaming (or integration) has been a part of rural Manitoba's education system since the days of the "one room schoolhouse".

> Small schools remain common in rural Manitoba. In 1990, 38 schools (10 percent) had one teacher. A total of 113 schools (29 percent) have 5 or fewer teachers (includes those with one), and 70 more (18 percent) have fewer than 10 teachers. Overall, therefore, 183 schools or 48 percent of all schools have between 1 and 9 teachers (Rounds, 1991:4).

In the past, small schools were not a pedagogical choice but existed because of economic necessity. Similarly, with very small populations of special needs students in large geographic areas, many school divisions in Agro-Manitoba had no alternative but to offer their special needs students some type of individualized program within a regular classroom.

Recently, an increased number of special needs students have been placed in regular classrooms because of pedagogical and legislative decisions, and economic necessity. Many parents and educators have decided that "least restrictive environment" means regular classrooms for their special needs students. Many regular classroom teachers have not received special education training during their university experience. This is especially true for teachers at the senior years level who may have little experience with special needs students. Teachers who graduated prior to 1982 were not required to take special education courses as part of their training, and they now are faced with the challenge of planning and implementing modified programs and Individualized Education Plans (IEP) for their special needs students. To do this effectively, educators of special needs students need a wide variety of information (McLoughlin and Lewis, 1990). They need effective access to diagnostic services to plan special programs and to monitor and evaluate the programs once they have been implemented.

A variety of practices are used to deliver diagnostic services to special needs children in rural Manitoba. A description of current practices in school divisions is compared with recommended practices identified in recent research. Comparison was completed to identify strengths and weaknesses in the Manitoba system. Although an indepth discrepancy analysis of the Manitoba circumstance and the "ideal" was not possible, a synthesis of recommended practices is utilized as a basis for recommendations on modification and improvement. It should be noted that there is a wide spectrum of views on recommended practices by experts in the field.

Definitions

One difficulty in research is the variety of terms used in special education. The following definitions are provided to clarify meaning.

Special Education: "Specially designed instruction to meet the unique needs of handicapped students" (McLoughlin and Lewis, 1986 and 1990). Alternately, defined as "Instruction that is specially designed to meet the unique needs of the exceptional child" (Winzer, Rogow, and David, 1987). Exceptional Children are "Those who have difficulty in realizing their full potential. Their intellectual, emotional, physical, or social performance falls below or rises above that of other children" (Winzer, Rogow, and David, 1987).

Diagnosis is not defined consistently by different authors and educators. "In special education, diagnosis may have any of several meanings. It may refer to a statement of the student's physical or psychological status, or it may refer to the category of handicapping condition into which the student is placed. Diagnosis may also refer to a statement of what and how the student should be taught. The three definitions do not necessarily relate to each other" (Howell and Morehead, 1987). Others define diagnosis as "The art of identifying disease from its symptoms" (Winzer, Rogow, and David, 1987). Yet another definition of diagnosis is "The process of establishing the cause or causes of an illness or condition and prescribing appropriate treatment" (McLoughlin and Lewis, 1986 and 1990).

Assessment may be used as a synonym for diagnosis, or it may be used as a more encompassing term which includes diagnosis. It may be defined as "The systematic process of gathering educationally relevant information in order to make legal and instructional decisions about the provision of special services to exceptional students" (McLoughlin and Lewis, 1986 and 1990). Further delineation includes "The process of determining whether a child exhibits a problem, what the problem is, its causes, its potential course, its developmental consequences, and the best approaches to intervention and remediation" (Winzer, Rogow, and David, 1987).

Assessment may be divided into formal and informal assessment. Formal assessment is defined as "... procedures that contain specific rules for administration, scoring, and interpretation; generally norm-referenced and/or standardized." Informal assessment, on the other hand, involves "... procedures without rigid

administration, scoring, and interpretation rules; includes criterion-referenced tests, task analysis, inventories, etc." (McLoughlin and Lewis, 1986 and 1990).

Many terms in special education are shortened into acronyms which further complicates both reading and discussion with experts. A list of acronyms used in this report is provided in Appendix A.

Special Education in Canada

Winzer, Rogow, and David (1987) describe the status of special education in Canada and suggest that it has undergone many recent changes. Changes range from parameters of the school's responsibility to program delivery and program implementation. This results in new challenges and new roles for teachers, and many regular classroom teachers now are responsible for direct instruction for many special needs students. "During the school years, approximately 15.5 percent of the Canadian school-age population will be considered exceptional. These children will require special education services for at least some part of their school career (Canada, Council of Ministers, 1983)" (Winzer, Rogow, and David, 1987:2).

"There is relatively little standardization in the study of exceptional children. There is not a single consistent and universally accepted method of describing different kinds of children" (Winzer, Rogow, and David, 1987:4). Classification systems may be based on deviation from the norm, or underlying causes, or educational achievement. In spite of these restraints, to be considered exceptional there must be a demonstrated clear need for the student to receive support services provided by psychologists, speech therapists, counsellors, and other professionals.

Even though some specialists state a distrust of labels, they continue to use categories that are accepted in Canada: intellectual differences, sensory handicaps, communication disorders, physical handicaps, and multiple handicaps. These categories have developed over the past 35 years and are "constantly being reconceptualized, reconsidered, and renamed" (Winzer, Rogow, and David, 1987:5). This is due partly to the involvement of so many professions, such as medicine and social work, in special education. Any classification system oversimplifies complex situations.

Many terms are used as synonyms for special-needs. These include *disabled, impaired, atypical, dysfunctional, exceptional,* and *high-risk.* These "varying definitions and descriptions of disabilities" (Winzer, Rogow, and David, 1987:8) are one reason why it is difficult to obtain accurate Canadian prevalence figures (percentage or proportion of the population that falls into a given category). Other complications include changing diagnoses, multiple handicaps, problems of early identification, the stigma of identification, survey problems and sampling errors, unidentified populations, and lack of a national survey (Winzer, Rogow, and David, 1987).

History

"[In the 1940's and 1950's] there was a great extension of special education services, greater specialization of services, and an increased public involvement with all phases of training and care for exceptional children" (Winzer, Rogow, and David, 1987:89). However, during the 1950's and 1960's much criticism was directed at special education, especially the practice of segregated special classes. Kendall (1980) and White (1980) report that during the late 1960's and 1970's provisions were made to provide special education services to mildly handicapped children. Previously, this population had not received special help. The result was "a phenomenal growth of special education services in Canada" (Winzer, Rogow, and David, 1987:10).

Parent organizations have been influential in the demand for and growth of special education services in Canada. Lusthaus and Lusthaus (1982) report that parents of exceptional children are more involved in making educational decisions than are parents of regular children. Their proactive advocacy concerning the school's providing for their children had significant impact on education across North America (Gearheart, Weishahn, and Gearheart, 1988).

Public Law 94-142, the Education for All Handicapped Children Act, was passed by the United States Congress in 1975 and became law in 1977. The basic provisions of PL 94-142 require diagnostic/assessment information developed from ...

> evaluation of the child in all areas of suspected disability, and in a way that is not biased by language, cultural characteristics, or handicaps. The evaluation must be performed by a multidisciplinary team, and placement and planning must not be based on any single evaluation criterion (Winzer, Rogow, and David, 1987:92).

Its principles of normalization and least restrictive environment have made their way into Canadian special education practices.

Special education in Canada has followed the American model (McMurray, 1980), even though there is no Canadian equivalent to Public Law 94-142. The only federal Canadian legislation that involves the rights of exceptional children is the Declaration of Human Rights. All ten provinces have their own school system based on provincial education legislation. Newfoundland, Nova Scotia, Quebec, Ontario, Manitoba and Saskatchewan have some form of legislation to guarantee access to special education (Winzer, Rogow, and David, 1987).

Many Canadian reports from the late 1960's onward questioned segregated schooling for exceptional children. Many exceptional children have been included in the public school system as a result of mainstreaming, or the inclusion of exceptional children in regular classrooms. "However, the law was never intended to force schools to educate all exceptional children in the regular classroom (Abeson and Zettel, 1977)" (Winzer, Rogow, and David, 1987:91). Some exceptional children do not function well in a regular classroom; there needs to be a cascade of services available along a continuum ranging from homebound/hospital instruction to regular classroom instruction. Regular classroom teachers need the support of resource teachers, principals, psychologists, speech therapists, and other childcare personnel.

The practice of labelling students is useful for administrators to obtain funding for special services (Winzer, Rogow, and David, 1987). Because they are useful, administrators likely will continue to use labels for administrative purposes.

Because labelling offers few benefits at the classroom level, however, educators of special needs students are now focusing on the individual needs of the child, rather than the child's category of disability. To do this, they depend upon a careful analysis of each child's overall academic, physical and personal patterns of strengths and weaknesses (Winzer, Rogow, and David, 1987). This non-categorical approach reduces the negative effects of labelling and is more useful in planning educational programs to meet individual needs.

CONCEPTS AND CONFLICTS

This review is organized into three sections. The first section examines the controversy between formal and informal assessment methods. The second summarizes information concerned with the referral process. The final section focuses on recent concepts in reading diagnosis.

Formal and Informal Assessment

Assessment protocols and procedures for diagnosis of special needs are the most pressing concerns in special education today. Assessment for special needs children is an important, and by no means easy, undertaking. "Assessment is one of the most complicated of human endeavors" (Salvia and Ysseldyke, 1988:526).

One complication is the choice facing education professionals seeking information appropriate to making responsible and effective decisions concerning special needs children. Either formal or informal assessment procedures are recommended strongly by proponents. Twenty years ago, Holmes and Docter (1972) used the terms *assessment* and *testing* as synonyms. Their criteria for a competent assessment system dealt with some form of standardized testing.

Five early criticisms of standardized testing were based on the validity and utilization of tests: 1) tests discriminate against some individuals, 2) tests predict imperfectly, 3) the rigid use of test scores, 4) assumption that tests measure innate characteristics, and 5) tests as self-fulfilling prophecies. Five other criticisms were independent of test validity arguments: 1) tests have a harmful effect on the shaping of cognitive styles, 2) tests shape school curricula and restrict educational change, 3) tests distort an individual's self-concept and level of aspiration, 4) tests select homogeneous educational groups, and 5) tests invade privacy (Holmes and Docter, 1972).

Tests (especially intelligence tests) have been a part of special education since World War I and were used to assign students to special segregated classes. These standardized tests also were used for deciding which students would receive different instructional programs. Tests were criticized and "viewed as tools that are used to make selection decisions that may significantly limit an individual's life opportunities" (Ysseldyke, 1986:10). During the 1960's and early 1970's using standardized intelligence tests to test cultural and linguistic minority groups came under increasing criticism.

A review of the studies of several researchers identified several issues related to intelligence testing. These included 1) the nature and definition of intelligence, 2) the contribution of both heredity and environment to intellectual performance, 3) whether IQ tests are useful and/or accurate, and 4) whether IQ tests should be used with minority groups. Procedures established in response to these criticisms were "that testing be conducted in the language of the student, that measures be nondiscriminating and validated for the purpose for which they are used, and that no single test score be the sole basis for determining special education placement" (McLoughlin and Lewis, 1986:151). Research from the early 1980's shows that these issues have not been resolved, as "debate continues over measures of intellectual performance, their proper use, and social consequences" (McLoughlin and Lewis, 1986:152).

Other standardized tests that have been criticized include those used to diagnose learning disabilities. Areas of technical soundness of standardized tests that have been questioned include 1) the recency of standardization, 2) representativeness of norms, 3) reliability, 4) validity, and 5) uses of the data (McLoughlin and Lewis, 1986). Another area of concern is that some examiners lack expertise in administering, scoring, and interpreting the results of tests.

Over the last 20 years, two approaches have developed in response to criticisms of formal assessment. One approach is to improve standardized tests, and the other to develop alternatives to standardized tests.

The work of McLoughlin and Lewis is a respected guide in the field of diagnostic assessment of special needs students. Their approach includes both formal and informal assessment, and they list 11 points that describe ideal general educational assessment practices (McLoughlin and Lewis, 1990:6):

1. Assessment is tailored to the individual needs of each exceptional student.
2. Assessment data are used to make legal and instructional decisions concerning handicapped students.
3. Assessment identifies educationally relevant information, such as instructional goals and objectives.
4. The learning environment is evaluated as well as the student's response to questions and tasks.
5. A variety of procedures are used in assessment, not only standardized tests.
6. Assessment is characterized by a team approach, and the special educator is an important member of that team.
7. Professionals use nondiscriminatory assessment procedures.
8. Instructional programs are continuously evaluated or monitored.
9. Procedures are available to attend to the assessment needs of preschool children and the career/vocational needs of older students.
10. New tests and other procedures to assess academic, language, and other skill areas continue to be developed.
11. Computer technology is being harnessed to facilitate test administration and scoring and the interpretation and reporting of assessment data (McLoughlin and Lewis, 1990:6).

Current practices for assessing learning aptitude include both group and individual tests. Usually individual intelligence tests are administered by licensed school psychologists. Assessments used to identify mental retardation usually include adaptive behaviour. This is not the case for learning disabilities and behaviour disorders where students may have trouble meeting expectations in situations outside the classroom.

Traditionally, tests of specific skills such as memory are used to diagnose learning disabilities. Learning strategies and study skills recently have been added to this area of assessment. Measures now include readiness tests, hearing and vision screening, individual tests of a particular ability area, and informal measures. Discrepancy analysis, based on a considerable difference between actual and expected achievement in subject matter areas, is used to determine eligibility for learning disabilities services.

Even though use of informal methods to complement standardized tests is recommended, Davis and Shepard (1983; in McLoughlin and Lewis, 1990:590) conclude that "most surveys of assessment practices indicate the predominant use of standardized tests and not very good ones at that." Reasons for concern with this situation include: 1) the automaticity of choosing tests over informal measures, 2) low esteem held for informal techniques, 3) devalued information from educators who use informal measures, and 4) the question of how to measure the reliability and validity of informal techniques (McLoughlin and Lewis, 1990).

Salvia and Ysseldyke (1988:8) report that in spite of all the criticism of using only tests to make classification decisions, "most federal and state regulations require that decisions be test based." This indicates that testing continues to be the basis for classification decisions.

Curriculum-based measures also have been developed to help make classification decisions. These include Deno's (1985) peer referencing and Marston and Magnusson's (1985) direct and frequent measurement (McLoughlin and Lewis, 1990).

Gearheart and Gearheart (1990:10) reached a more positive conclusion about standardized tests. "Today there is a wider variety of standardized tests, more valid and reliable tests, and more knowledgeable assessment personnel than at any time in the history of the testing/assessment movement."

"Historically, tests were constructed to compensate for the inadequacies of observation and decision making based on subjective feelings about a student" (Salvia and Ysseldyke, 1988:524). Norm-referenced tests can protect children when they are appropriately administered, scored, and interpreted. Two major guidelines are that technically adequate tests should be used only for the purposes for which they were developed, and technically inadequate tests should not be used at all. Even when these criteria are met, however, the result is a rank score "that is a limited piece of information, and even a good norm-referenced test does not explain why students perform as they do." Knowing how a particular score was achieved is important information for teachers and students.

Much assessment in the United States is mandated by law (Salvia and Ysseldyke, 1988). Most states require team members to provide two types of assessment information, general intellectual level and academic performance. Both norm-referenced standardized tests and informal assessment procedures should be used (McLoughlin and Lewis, 1986).

Informal assessment procedures include observations, work sample analyses, task analyses, checklists, rating scales, interviews, sociograms, language samples, informal inventories, diagnostic teaching, and criterion-referenced tests. These procedures are connected closely to the curriculum and can provide information to help set goals and to modify instruction.

Diagnostic teaching is an effort to link assessment to instruction. Ability training views poor academic performance as a result of "within-student deficits, disorders, dysfunctions and disabilities" (Ysseldyke, 1986:19). Task analysis, on the other hand, views environmental factors as the cause. In ability training "deficits are identified and remediated prior to instruction." Task analysis emphasizes assessment of the strengths and weaknesses of skill development, analysis of specific skills, and teaching of specific skills (Ysseldyke, 1986:19).

"Increasingly, educators are advocating informal over formal assessment, especially in instructional decision making and in evaluating pupil progress" (Salvia and Ysseldyke, 1988:22). This has led to an increase in curriculum-based assessment over the last ten years. Characteristics of curriculum-based assessment (or diagnostic teaching) include: "1) direct observation and analysis of the learning environment, 2) analysis of the processes used by students in approaching tasks, 3) examination of pupil products, and 4) control and arrangement of tasks for students" (Salvia and Ysseldyke, 1988:22).

Three possible approaches to assessment are 1) assessing the learner, 2) assessing the instructional environment, and 3) instructional diagnosis. Although criticized frequently and strongly, the most frequently used approach, and the one most often taught in universities, is assessment of the learner (Salvia and Ysseldyke, 1988). Approaches to assessment also may be classified as norm-referenced, criterion-referenced, ecological, or informal. (Gearheart and Gearheart, 1990).

Referral Process

Careful consideration of the purposes of assessment relating to referral procedures highlights recommendations for school district practices. These are summarized in nine categories: 1) purposes of assessment and referral steps, 2) screening, 3) prereferral, 4) classification/eligibility, 5) referral, 6) program planning (Individual Education Plan), 7) teams 8) critical issues, and 9) improvements.

Purposes of Assessment and Referral Steps

McLoughlin and Lewis (1986) outlined five purposes for educational assessment: 1) screening, 2) determining eligibility, 3) program planning, 4) monitoring student progress, and 5) evaluating a program. Ysseldyke (1986) reviewed the work of Salvia and Ysseldyke (1981) and listed six uses for assessment: 1)referral, 2) screening, 3) classification or placement, 4) intervention planning, 5) pupil evaluation decisions, and 6) program evaluation decisions. These two lists have both commonalities and differences.

According to other authorities (McLoughlin and Lewis, 1986), the steps that generally are followed in an assessment should incorporate legal requirements, common practices, and useful strategies. Recommended steps include: 1) screening, 2) referral, 3) design of IAP, 4) parental permission for assessment, 5) administration, scoring, and interpretation, 6) reporting results, 7) deciding eligibility for special education, 8) design of the IEP, and 9) parental agreement to the IEP.

Ysseldyke (1986:21) states emphatically that "the only legitimate purpose for assessment is to improve treatments or interventions for students." He further stresses that emphasis on within-student disorders has been and continues to be a misdirection. He cites the argument of Englemann, Granzin, and Severson (1979) that instructional diagnosis should be the first part of an assessment.

Ysseldyke lists five factors that interact in a complex fashion to influence the effectiveness of any instructional intervention: 1) the characteristics of the student, 2) the nature of the intervention, 3) the characteristics of the teacher, 4) the setting, and 5) the particular kind of behavior change one is trying to bring about. He concludes that emphasis should be placed on the "development of measurement technologies that will enable us to make better decisions for individual students" (Ysseldyke, 1986:21).

Gearheart and Gearheart (1990:5) list four purposes for assessment: 1) placement-related, 2) readiness-related, 3) summative, and 4) diagnostic. They state that the purpose of diagnostic assessment is "to provide information about strengths and weaknesses in some given subject or skill area and to offer guidance on what to do next." They suggested that both published diagnostic tests and informal procedures may be used for each of their four kinds of assessment.

These authors outlined what they think the steps in the referral process should be (Gearheart and Gearheart, 1990:39):

> prereferral considerations, referral, parent permission for assessment, multidisciplinary assessment, multidisciplinary meeting to evaluate assessment results, developing of individualized education program (IEP), initiation of special programming, further assessment to determine program effectiveness, and need for modifications or continued programming.

Salvia and Ysseldyke (1988:4-5) differentiate between testing and assessment. "Testing ... means exposing a person to a particular set of questions in order to obtain a score. That score is the end product of testing .... Assessment is the process of 1) specifying and verifying problems and 2) making decisions about students." They group the usual problems to be assessed in educational settings into three categories: 1) academic, 2) behavior, and 3) physical. Their list of decisions to be made includes 1) referral, 2) screening, 3) classification, 4) instructional planning, and 5) pupil progress. Governmental decisions and guidelines, court decisions, professional organizations, and university training programs all influence assessment practices.

Screening

Group administered aptitude and achievement tests are used for screening. Individually administered tests are recommended for identifying strengths and weaknesses in various skills and are used for determining eligibility for special services.

Prereferral

Salvia and Ysseldyke (1988) discuss five stages of prereferral assessment and intervention described as ideal practice. These stages are 1) request for consultation, 2) consultation, 3) observation, 4) conference, and 5) formal referral.

Classification/Eligibility

"The practice of assessing students with specific diagnostic labels and determining eligibility for special education on the basis of specific categories of disabilities is being strongly questioned" (McLoughlin and Lewis, 1990:598). Experts in assessment have problems making eligibility decisions, especially for learning disabilities. "There is also a fundamental question of whether learning disabled, emotionally disturbed, and mildly retarded students are really different" (McLoughlin and Lewis, 1990:598).

There is concern about the practice of labelling students. "*How can special education services be provided without the stigmatizing aspects of the assessment and placement process*? is a question asked by everyone engaged in serving handicapped students" (McLoughlin and Lewis, 1986:525). The classification system which governs the current delivery of special education services has evolved over the years. "Each of the special education categories was created when it was recognized that there was a group of students who failed, who did not meet the criteria for those categories then in existence, and who had certain behaviors in common" (Ysseldyke, 1986:15). An example from the 1960's is the category of specific learning disabilities. It is current practice that students become eligible for special services and benefits through being classified as handicapped. Only very recent research has moved from "how to classify better" to "why classify at all?" (Ysseldyke, 1986).

Ysseldyke (1986) states that today's North American special education classification practices have been influenced by politics, economics, and social values. He used the classification for mental retardation as an example. In 1973 the American Association on Mental Deficiency changed the standard for mentally retarded from one to two standard deviations below the mean because too many minority and disadvantaged students were being labelled mentally retarded. The same thing may now be happening with Learning Disabled classifications because greater numbers of students are being classified as learning disabled. It is becoming more expensive to provide special services for these students.

"Usually, special services are much more costly than the services provided to students in general education" (Salvia and Ysseldyke, 1988:7). Eligibility requirements for these services require students to be evaluated by certified diagnostic specialists before they are eligible for special education services. These decisions must be made by teams of professionals to ensure accurate classification decisions.

However, several studies conclude that current classification procedures (both test scores and clinical judgment) do not result in accurate classifications. Ysseldyke (1986:22) states that nonhandicapped students are being classified as handicapped and the reverse may be true as well. He also concludes that "we need a dramatic shift in efforts away from improving categorization to improving instruction."

Referring to North American education, Salvia and Ysseldyke (1988:498) comment that "it is very clear that society does *not* choose to help all students who fail to make adequate progress." In order to receive special funding, a student must be classified as having a particular handicapping condition. There are alternatives to categorical assessment such as an ecological approach and minimum competency testing (MCT), although there have been many problems for handicapped students using MCT.

Referral

"Referral has two meanings. It is a request for help. It is also a request for evaluation" (Salvia and Ysseldyke, 1988:488). This suggests that much assessment and diagnostic teaching occurs prior to actual referral. Referral is an important decision because "it sets in motion a search for pathology that most often results in finding pathology" (Ysseldyke, 1986:15). Doris (1979:10) defines diagnosis as "a pathology oriented process activated by someone who thinks something is wrong with somebody else."

These warnings are supported by recent research findings. Algozzine, Christenson and Ysseldyke (1982; in Ysseldyke, 1986:13) "reported that nationally 3-6% of the school-age population is referred every year for psychoeducational evaluation. They reported that of those referred, 92% are tested; of those tested 73% are declared eligible for and placed in some kind of special education program." The most common reasons for referring students are behaviour and academic problems. Because Canadian practice is similar to that in the U.S., there is little reason to believe a significant variance occurs between countries.

Usual information required on a referral form includes "reason for the referral, what interventions have been tried already, and related information that assessment personnel find useful" (Gearheart and Gearheart, 1990:40). The actual forms may vary considerably among areas.

Current referral practices are mixed. Traditionally teachers referred students to other professionals to find out what is wrong. In current North American practice, teachers who seek help in providing an appropriate educational program in the least restrictive environment may emphasize prereferral assessment before making a formal referral.

Program Planning (Individualized Education Plan)

"Most people would agree that it is desirable to individualize programs for students in special and remedial education since the regular education programs have not proved beneficial to them" (Salvia and Ysseldyke, 1988:515). Instructional planning includes decisions about what to teach and how to teach. Three major concerns when deciding what to teach are selection of goals, selection of algorithms (the means used or way of teaching), and selection of objectives.

A continuum of services should be available for program planning, ranging from a regular classroom setting (with support) to a residential setting. Individual Education Plans (IEP) must be reviewed at least once each year (McLoughlin and Lewis, 1986). Evaluation of the IEP should be both formative (ongoing) and summative. Someone should monitor the procedures that are included in an IEP to evaluate if they really are working (Gearheart and Gearheart, 1990).

The Team Approach

A team approach is recommended for placement decisions and for planning and evaluating Individualized Education Plans (IEP). Teams may be composed of school support personnel, medical personnel, social/career needs personnel, and others. The variety and number of team members is determined by the team's purpose and the needs of the student.

McLoughlin and Lewis (1986) provide a comprehensive overview of possible team members, and their recommendations mirror the established practice presented in North American special education texts. A review of twelve current texts on mainstreaming shows the following recommended pattern. Regular classroom teachers contribute information about academic performance, social skills, and the emotional status of a student. Special educators and resource teachers may contribute more individualized data about academic, language, and behaviour disorders. School administrators contribute their knowledge of program options available in the school or division. Parents may contribute knowledge about the student's development, and the students can contribute their emotions, attitudes, and goals.

Psychologists may contribute information about general intelligence level, "level of ability and/or expectancy for the student, status of specific skills involved in learning, and emotional and behavioral status" (McLoughlin and Lewis, 1986:12). Speech/language pathologists are in a position to provide information about a student's communication skills. Physicians, nurses, and other medical specialists may contribute information about health problems, which may include hearing and vision screening results. Social workers and counsellors provide social, emotional, and career-vocational information. Occupational and physiotherapists may be asked to provide information about gross and fine motor development. Tutors, aides, employers, and grandparents also may provide useful information. Gearheart and Gearheart (1990) support the use of large assessment teams. Current life circumstances, developmental history, and extrapersonal factors should be considered in assessment. Information may be current or historical, and gathered directly or indirectly.

McLoughlin and Lewis (1986:36) discussed placement in the least restrictive environment as a team decision. Handicapped students should be educated in a regular classroom "to the maximum extent appropriate."

In theory, these very large assessment teams are established in the best interests of special needs children. In practice, they are expensive and may not be as effective as desired. McLoughlin and Lewis (1990) summarize the work of several researchers who studied assessment teams.

> Studies of the workings of the all-important assessment team have not shown positive results. Participation has been weak by all concerned parties, particularly parents. The interdynamics of the situation suggests dominance by certain groups (Poland, Thurlow, Ysseldyke, and Mirkin, 1982). Compliance with due process procedures is not always evident, and there is evidence of role confusion and professional competition (Yoshida, 1984). The actual meetings studied seemed to lack structure and purpose, contributing to lower quality decision-making (Ysseldyke, Thurlow, Graden, Wesson, Algozzine, and Deno, 1983:16).

The team process has been criticized on the basis of the nature and quality of the participation of its members. Researchers have found that participants with data are most influential and tests dominate the decision making process. The participation of regular classroom teachers and parents is limited. Team members may not understand what their roles are and "meetings tend to be unstructured, nongoal oriented, as well as limited in individual contribution" (McLoughlin and Lewis, 1986:521). There is a need for structure in the assessment process and training for group members.

Ysseldyke (1986) studied the practices of the traditional education placement team meetings. He concluded that decisions often are made before meetings and then conveyed to parents at team meetings. Parents, school administrators, special education teachers, school psychologists, and classroom teachers are the most frequent members of these teams. Parents participate little, and regular classroom teachers are least happy with the team decision-making process. Teams spend most of their time discussing academic information. Test results are used most often to make decisions and "while exceptions could surely be shown, for the most part professionals used technically inadequate tests" (Ysseldyke, 1986:18).

Critical Issues

Several critical assessment issues are reported by McLoughlin and Lewis (1986:15).

> Professionals define and conduct educational assessment in various ways. Current practices do not seem cost-effective (Ysseldyke and Algozzine, 1982) and reflect little consensus in terms of choice of procedures (Ysseldyke, Algozzine, Regan, Potter, Richey, and Thurlow, 1980). Tests meant for one purpose are used for others.

Other critical assessment issues are discrimination, due process rights, confidentiality, the influence of incidental data (sex, race, socioeconomic status), the rights of minority students, and bilingualism (McLoughlin and Lewis, 1986).

A time frame of 13-15 hours at a cost of $1,800 (U.S. 1982 dollars) per assessment was estimated. This is significant when viewed in light of studies that show team decisions are not always based on assessment data. Recent studies argue that "our assessment practices are not cost effective, and results obtained are irrelevant to programming and merely confirm initial impressions" (McLoughlin and Lewis, 1990:589).

Another concern is a vague assessment process. "In a computer-simulated study of the decision-making process, a group of 159 varied professionals chose nearly 50 different devices to make the same outcome decision" (McLoughlin and Lewis, 1986:516).

Even though assessments of special needs students require a team approach, there may be obstacles such as overlaps in function and communication. "Unless stringent measures are quickly taken, the validity of the assessment process as a basis for educational planning can be challenged at every level" (McLoughlin and Lewis, 1990:601).

Improvement in Assessment

McLoughlin and Lewis (1990:604) list thirteen future goals for the improvement of educational assessment:

- Develop better, simpler, and quicker testing technology.
- Enhance the respectability of educational assessment through greater quality control.
- Improve the level of meaningful parental participation in the process.
- Better assess the very young, adolescent, and adult handicapped individual (also account for distinctive needs of the rural and urban, minority, and other groups).

- Try to describe both how and what the students learn.
- Make a special study of learning environments.
- Maintain educational assessment as an ongoing process of monitoring and evaluating students' programs.
- Make team assessment and team decision making smoother.
- Develop the role of special educators as synthesizers of team results, while continuing their dual role as teachers.
- Place greater stress on the programming goal for assessment, while clarifying the legal application of data.
- Maintain a balance between primary direct skill assessment and secondary assessment of correlates and possible etiology.
- Establish a greater link between regular and special education assessment practices.
- Encourage school administrators to give educators the time, devices, and conditions needed to conduct thorough educational assessments.

Sternberg (1986) believes that we should do more than just measure intelligence. We should teach intelligence through programs which have been developed recently to supplement the standard curriculum

Reading Diagnosis

An examination of the most recent research in reading diagnosis shows that standardized/formal tests are still part of the reading assessment picture, but are not the dominant criterion that they once were. Lewandowski and Marten (1990) recommend an intelligent use of standardized reading tests that considers content relevance, technical adequacy, and test utility.

Many authors, including Valencia and Pearson (1987), Brozo (1990), and DeFina, Anstendig, and DeLawther (1991), criticize standardized tests and plead for a movement towards alternative diagnostic techniques. Valencia and Pearson (1987:726) state that "Reading assessment has not kept pace with advances in reading theory, research, or practice."

"Reading diagnosis today is at a crossroads. There has been a general outcry for changes in the way we assess a student's reading ability" (Kinney and Harry, 1991:643). The reading process is no longer seen as an accumulation of separate skills but as a complex and interactive process. "Recent research has led to a definition of reading as a constructive process whereby meaning is obtained through the interaction of several factors such as text characteristics, reader characteristics, and task demands."

Brozo (1990:527) justifies the need for a change in assessment: "while research has informed us that reading comprehension is influenced by motivation, interest, prior knowledge and values, the text, socio-cultural factors, and the literacy context, our diagnoses remain largely 'deficit driven'." Sternberg (1991:540-541) explains that "typical aptitude and achievement test scores provide only a narrow measure of student aptitudes and achievement and that the test scores provide not only an incomplete but also a distorted view of student performance." He states that his criticisms of reading tests are applicable to other diagnostic areas as well. He advocates creating more realistic tests of real world reading behaviour. "Reading tests are at variance in their demands with the demands of reading as it actually occurs in everyday life." His criticisms are summarized in the following twelve points:

1. Reading test passages are short, whereas in school/everyday life passages are longer.
2. Reading tests measure massed learning whereas most everyday learning is distributed.
3. Reading test recall is immediate, whereas recall is delayed in most school or work settings. In school and at work, people are almost never tested on material immediately after it is read.
4. Reading test recall is entirely intentional, and not at all incidental.
5. Reading test reading is usually for a single question type, typically multiple choice.
6. The reasoning in reading test passages is too good.
7. Reading tests measure evaluation of but not construction of arguments.
8. Reading test passages tend to be emotionally neutral.
9. Reading test passages are usually unmotivating and even boring.
10. Reading test situations minimize distractions.
11. Reading tests are for a single purpose.
12. Reading tests do not control for a student's desire to read.

Sternberg (1991:544) advised extreme caution in "generalizing from reading test performance to reading outside reading test situations."

There are many examples of alternative diagnostic reading techniques in current literature. The Integrated Assessment System of Farr and Farr (reviewed by Werner, 1992) addresses several criticisms of standardized reading achievement tests. "Rather than measuring quantifiable discrete subskills, this system helps teachers assess reading and writing skills using genuine, process-oriented, holistic reading/writing tasks" (Werner, 1992:416). The whole focus of this assessment system is for instructional purposes. The system has two sections, Language Arts Performance Assessments and Language Arts Portfolios.

Performance Assessments are designed to duplicate real classroom reading and writing tasks. Reading passages are longer, include fiction and nonfiction, are meant to appeal to students, and suit their background knowledge. Students are asked to synthesize information from more than one type of text and to use several kinds of writing. Guided Writing Activities take students through planning, drafting, and revising stages. "Teachers are encouraged to adapt the directions to make the tasks similar to typical reading/writing assignments in their classrooms" (Werner, 1992:417). Activities may be planned over several class periods, the tasks are open-ended, more than one response is acceptable, and students may collaborate as they would during instruction. Scoring considers response to reading, management of content, and command of language. Guidelines are included for obtaining process-oriented information through observation while testing. Teacher flexibility is encouraged. An annotated bibliography of trade books is included for each of the reading/writing prompts to encourage the integration of the performance assessments with the classroom language arts curriculum.

Language Arts Portfolios are used to collect both typical and best work as chosen by students and teachers. Informal assessment tools which may be used are reading logs, writing logs, reading and writing interviews, attitudes and interests summaries, and student/teacher conference summaries. Other documents encourage students to think about their own reading/writing progress. The system has many strengths and can offer an alternative to standardized tests.

The Dynamic Assessment Procedure (DAP) of Kletzien and Bednar (1990) is designed specifically for at-risk readers. It is composed of three steps: initial assessment and strategy analysis, mediated minilesson, and post-assessment and strategy analysis. "In order to help these at-risk readers take control of their reading and develop more confidence in their abilities, it is necessary to teach them how and when to use reading strategies" (Kletzien and Bednar, 1990:529). The DAP combines instruction with assessment and provides students with an opportunity to learn about their own capabilities.

Brozo (1990:523) emphasized the interactive aspect of assessment to discover how at-risk students learn best. "The goal of interactive assessment ... is to discover the conditions under which a student will succeed in reading, rather than merely describing a student's current status as a reader." This is the opposite of a standardized test which is a static measure of reading comprehension.

The assessment process he advocates looks like "a well planned reading lesson" (Brozo, 1990:523). The steps include: 1) a diagnostic interview, 2) determining passage placement, 3) preparing to read, 4) reading silently first, 5) oral reading, and 6) after reading activities. He shares Pearson and Valencia's (1987) view that testing and teaching are integrated and virtually indistinguishable.

Tests and Informal Reading Inventories (IRI) "no longer yield the type of information necessary to plan an appropriate instructional program" (Kinney and Harry, 1991:643). An inventory was developed that goes beyond the separate skills measurement yielded by traditional diagnostic tests. If factors such as text characteristics, reader characteristics, and task demands are important in the reading process then they should be included in any diagnostic process that attempts to measure reading ability. Developing background knowledge, vocabulary, use of text structure, and QAR (question-answer relationship) strategies all are part of the instructional program that is based on the strengths and weaknesses assessed by this reading inventory.

DeFina, Anstendig, and DeLawter (1991) designed a placement exam (Test of Writing and Reading, or ToW&R), that demands reactions to reading material as well as recall of information in the material. The test is designed to provide diagnostic information about reading and writing strengths and weaknesses. The authors claim that curriculum development cannot occur without information derived from the kind of assessment they developed.

In 1992 the International Reading Association's Disabled Readers Committee conducted a survey to identify current trends and practices in reading assessment. The purpose of the study was to find out if reading teachers are using skills-oriented (diagnostic/prescriptive) procedures or if they are moving towards holistic/naturalistic procedures. "In general, the innovative assessment approaches cited as well as those listed as most often used tend to be more holistic/naturalistic in nature" (McCormick, Cooter, McEneaney, 1992:598).

The April 1993 issue of the Journal of Reading will be devoted to *literacy assessment*, and will report dramatic changes that are taking place in this area. Topics will include alternative forms of literacy assessment, portfolio assessment, computer-adaptive testing, setting standards, and workplace literacy.

METHODS AND PROCEDURES

There are five stages in the implementation of the research design: 1) a pilot study, 2) a survey of all Agro-Manitoba school divisions, 3) analysis of survey data, 4) an interview with the Child Care and Development Branch (CCDB), and 5) an interview with the Diagnostic Support Centre (DSC). All stages are designed to provide the information necessary to formulate an analysis of the status of diagnostic services in Agro-Manitoba school divisions.

The Pilot Project

Interviews and informal discussions were conducted over several weeks with key personnel in special education in Brandon School Division #40. These include the Administrator of Special Education and the Facilitator of Special Education Programs. The purpose was to gather background information about special education in Brandon School Division in particular, and other rural Manitoba divisions in general. Discussion

included sources of diagnostic/assessment information, the referral process, and the services the DSC provides to rural divisions.

An interview with the director of the Learning Disabilities Association of Manitoba (LDAM) revealed that this agency does not provide diagnostic services to its members. It is a support group that provides information about resources which are available in the community. According to their May 1992 newsletter, "LDAM does not endorse any particular treatment, product, evaluation, theory or remedial program." LDAM advises parents to seek diagnostic/assessment services through their child's classroom teacher and the referral process which has been established in the school.

Most of the other special interest groups located in Agro-Manitoba do not provide diagnostic services. The diagnostic services that are provided by these agencies are mainly for pre-schoolers (screening) or for older students who are finishing their schooling (vocational). Several resource teachers in Brandon provided perspectives concerning the same areas discussed with special education administrators.

A preliminary survey instrument was based on the information gathered from these sources, and was previewed by the Special Education Administrators from five divisions in Agro-Manitoba. Their reactions, questions, concerns, and new information were incorporated into the final survey.

Many positive comments were received about the importance of this research and assurances given that Special Education Administrators would possess the necessary information to complete the survey. Although the survey had a specific and limited purpose, and was meant to be administered only once to a very limited population, validity was important. The five Special Education Administrators contacted, and other colleagues interviewed, are experts in this field and pointed out errors, omissions, or ambiguous terms or questions. A copy of the survey is provided in Appendix B.

The Rural Division Survey

Information gathered during the Pilot Project was used to extend the assessment of diagnostic services to all 34 school divisions in Agro-Manitoba. Returns were requested from Special Education Administrators within 14 days and a follow-up letter was used to encourage returns. Twenty-six of 34 Administrators completed the survey (76.5 percent).

A cover letter assured respondents that no negative impressions would be fostered about any school division as a result of the survey; confidentiality would be respected and data would be presented only as summative results. Another letter to the Superintendents of all Agro-Manitoba divisions explained the nature of the research and asked for permission to include their divisions in the survey. There were no negative replies.

The survey consisted of 32 open and closed-form questions. Closed-form questions are easier for the respondent to fill in and for the researcher to analyze. They do not take long to complete, are relatively objective, and keep the respondent on the subject. Open-form questions require more time and effort from the respondent, but allow greater depth of response (Best and Kahn, 1986). However, responses are more difficult to analyze, so some data are not quantified. Since this was an exploratory and information-seeking exercise, even closed-form or restricted questions included an "other" category. This allows a place where respondents provide information which had not been anticipated by the researcher.

Parts IA and IB of the questionnaire deal with sources of diagnostic information in Agro-Manitoba. Clinical services, consultant services, and community services are the focus of Part IA. A checklist of standard services and a place for listing additional services is provided. Questions are asked about which services are shared with other school divisions and new programs or procedures to improve diagnostic/assessment services.

Part IB concerns the location of services (school division, or community), what diagnostic services are provided, which services are shared, and if any services are provided by other agencies. The same questions are asked for early (Kindergarten to Grade 4), middle (Grades 5 to 8), and senior years (Grades 9 to 12).

Part II includes ten questions about the referral process. Information sought focuses on numbers of special needs students, purchases made with block funding, segregated classes, the prereferral process, and IEP procedures.

Part III focuses on the DSC. Questions concern the numbers of referrals from rural school divisions, costs of using DSC services, kinds of information given by DSC, and kinds of problems referred to DSC. The final question ascertains whether or not the Special Education Administrators would like to make changes in DSC services.

Part IV asks Special Education Administrators to specify areas of diagnostic/assessment services with which they are satisfied and areas where they would like to make changes. Subjectivity and judgment were expected and requested. Each division was asked to submit 1) an Annual Division Action Plan (ADAP), 2) an IEP Form, and 3) a Resource Teacher Referral Form. A total of 17 ADAP's, 13 IEP forms, and 12 Referral forms were returned.

Analysis of Survey Data

Answers to closed-form questions were counted, percentages calculated, and results tabularized. Where possible, results are rank ordered with the most frequently listed responses appearing first. Answers to open-form questions were listed, and a similar process to closed-form question analysis was possible. Special educators use many different names for the same term (such as nurse, health nurse, public health nurse) and discussion with colleagues and special education experts was required in the initial sorting stage. Responses which are listed only by one or two divisions are not included in tables.

Interview at the Child Care and Development Branch

An interview was conducted at the Child Care and Development Branch (CCDB), Manitoba Department of Education and Training (July 7, 1992). The purpose of the interview was to secure information regarding normal special education diagnostic practices, and the goals for provision of diagnostic services to special needs children in Agro-Manitoba. An interview schedule related to the field survey was developed and followed throughout the interview. Open-form questions were used to encourage greater depth of response. Written notes were used to record responses and were organized after the interview was completed. A copy of the interview schedule is provided in Appendix C.

Interview at the Diagnostic Support Centre

The CCDB operates the Diagnostic Support Centre (DSC) in Winnipeg. This is a provincial resource which may be used by all divisions. Two visits were made to DSC. The first was a tour of the facilities and an informal discussion (July 2, 1992), which was followed by an interview (July 3, 1992). The purpose of the interview was to gain information about DSC programs and procedures. An interview schedule related to the field survey was developed and used throughout the interview. A copy of the interview schedule is provided in Appendix D.

THE STATUS OF DIAGNOSTIC SERVICES IN MANITOBA

School divisions in Agro-Manitoba were asked to list the clinical services that provide information for diagnosis/assessment of students (Table 1). All 26 responding school divisions have the services of psychologists and speech/language pathologists. No other listed service, however, is available to even half of the divisions. Of the 26 divisions that responded to the survey, 15 (58 percent) share some or all of their clinical services with other school divisions.

Table 1. The availability of clinical services that provide diagnostic/assessment information in rural school divisions in Agro-Manitoba, 1992

Clinical services	No. divisions	Percent
Psychologist	26	100
Speech/Language pathologist	26	100
Social worker	10	38
Native education worker	6	23
Reading clinician	4	15

School divisions in Agro-Manitoba listed the consultant services that provide information for diagnosis/assessment of students (Table 2). More than 90 percent of responding divisions have the services of the Diagnostic Support Centre, a hearing impaired consultant, an occupational therapist, and a multi-handicapped consultant. More than 80 percent of responding divisions have the services of all six listed consultant services. Of the 26 divisions that responded to the survey, 20 (77 percent) share some or all of the consultant services with other school divisions.

Table 2. Availability of consultant services that are sources of diagnostic/assessment information in rural school divisions in Agro-Manitoba, 1992

Consultant services	No. divisions	Percent
Diagnostic Support Centre	25	96
Hearing impaired consultant	25	96
Occupational therapist	24	92
Multi-handicapped consultant	24	92
Physiotherapist	23	88
Visually impaired consultant	21	81

School divisions were asked to list the community services that provide information for diagnosis/assessment of students (Table 3). Child and Family Services programs are available to more than 90 percent of responding divisions. More than 80 percent of divisions also have the services of the Society for Manitobans with Disabilities, Manitoba Health and Family Services, and the Child Development Clinic. The services of the Learning Disabilities Association of Manitoba, Brandon Mental Health Centre, and Arm Industries are available to less than half the responding divisions.

Several respondents point out that while available to their division, community services may provide support and advocacy rather than diagnostic information. Others note that some of these services are minimal, not always available for all children, and that there may be a long wait to obtain such services.

Table 3. Availability of community services that are sources of diagnostic/assessment information in rural school divisions in Agro-Manitoba, 1992

Community services	No. divisions	Percent
Child and Family Services	24	92
Society for Manitobans with Disabilities	23	88
Manitoba Health and Family Services	23	88
Child Development Clinic	21	81
Association for Community Living	18	69
Learning Disabilities Association of Manitoba	13	50
Brandon Mental Health Centre	10	38
Arm Industries	9	35

School divisions in Agro-Manitoba described the programs or procedures that they have implemented to improve diagnostic/assessment services for special needs students during the last five years (Table 4). The most frequently noted improvement (22 divisions) is an increase in resource teachers. This includes an increase in overall time, and the introduction of resource teachers at middle and senior years. Some are itinerant teachers shared by the schools within a division.

Increases are indicated in the number of guidance counsellors at early years (7 divisions). Also mentioned are increases in traditional services such as psychologists, and newly developed clinician positions for specific programs. Only one division reports no new programs or procedures during the past five years.

Several divisions note improvements in the area of establishing teams and procedures. Included are implementation of a referral process, an IEP process, release time for teachers to attend team meetings, and training with both formal and informal diagnostic instruments.

Table 4. Programs or procedures implemented during the last five years to improve diagnostic/assessment services in school divisions in Agro-Manitoba, 1992

Program or procedure	No. divisions	Percent
Increase in resource teachers	22	90
Increase in guidance counsellors	7	27
No new programs	1	4

School divisions were asked to list their school-based diagnostic/assessment services (Table 5). Resource teachers are listed for senior years by 22 divisions, for early years by 24 divisions, and for middle years by all 26 divisions. This substantiates a comment made during the pilot study that "in rural school divisions ... school based assessment at all levels is virtually limited to resource teachers."

There were 32 different responses listed for diagnostic services provided. Some are general and some specific. Achievement is listed by 17 divisions, but a wide variety of formal and informal assessment practices, both traditional and alternative, are mentioned. Twenty divisions do not share these services with other divisions. Other agencies, such as Health and Family Services, are listed as providing some services.

Table 5. School-based diagnostic/assessment services used in rural school divisions in Agro-Manitoba, 1992

School-based services	No. divisions		
	Early grades	Middle grades	Senior grades
Resource teacher	24	26	22
Guidance counsellor	5	6	5
Regular/class teachers	6	6	4
Clinicians	4	5	4

There were 26 different answers listed in response to a question concerning diagnostic services provided by divisions (Table 6). Psychologists and speech/language pathologists are listed by 18 divisions for early, middle, and senior years. Intelligence is mentioned 12 times, speech/language assessment 11, achievement 6, behavioral 6, and gross and fine motor skills 3 times. A variety of assessment practices are listed, but these are more formal and traditional than the list of school-based diagnostic services. Only 7 divisions do not share all or some of these services with other school divisions. Other agencies that are involved include Health, Family Services, and School Therapy Services.

Table 6. Division-based diagnostic/assessment services used in rural school divisions in Agro-Manitoba, 1992

Division-based services	No. divisions		
	Early grades	Middle grades	Senior grades
Psychologist	18	18	18
Speech/language pathologist	18	18	18
Classroom and resource teacher	4	4	4
Occupational and physiotherapist	3	3	3
Special Ed. coordinator	3	3	3

School divisions also were asked to list their community-based diagnostic/assessment services (Table 7). Public Health Nurses and the Child Development Clinic are mentioned most frequently for early years (Grades K-4), but 15 other agencies are listed once or twice. For middle years (Grades 5-8), 18 services are listed once or twice, but Child and Family Services and Mental Health are frequently mentioned. For senior years (Grades 9-12), 17 services are listed once or twice, but Child and Family Services, Mental Health, and Vocational Rehabilitation are mentioned most frequently. Diagnostic services provided for vocational

rehabilitation include the readiness of a client for pre-vocational or vocational training. Only one division does not share any services. Eight divisions share all of them.

Table 7. Community-based diagnostic/assessment services used in rural school divisions in Agro-Manitoba, 1992

Community-based services	No. divisions		
	Early years	Middle years	Senior years
Public Health Nurse	6	0	0
Child Develop. Clinic	4	0	0
Child and Family Services	0	3	3
Mental Health	0	5	5
Vocational rehabilitation	0	0	4

Status of the Referral Process

Divisions indicated the number of funded special needs students in their jurisdictions. In addition to block funded (Level I) students, who do not have to be identified for funding purposes, there were 463 identified and funded students in 26 divisions. All 26 divisions have Level II students (total n=392). The highest number in one division is 53.5 and the lowest is two. Six divisions have no Level III students, the highest number is nine, and the total is 64. Only four divisions report special funding students. Four other divisions, however, responded to this question with a question mark.

All divisions reported allocating block funds to a variety of purchases (Table 8). Most allocations are spent on human resources rather than materials. Teacher assistants and resource teachers are supported by block funds in most divisions.

Table 8. Allocation of funds received under special needs block funding

Allocation category	No. divisions	Percent
Teacher assistant	22	85
Materials and resources	18	69
Resource teachers	15	58
Special education teachers	4	15
Professional development	4	15
Gifted teacher	3	12
Guidance counsellor	2	8

Among the 26 school divisions, 15 provide segregated special classes and 11 do not. Of the 15 divisions that provide segregated classes, two stated "no, but ...", and listed qualifications that suggest at least limited special classes are available. Ten of the 15 divisions that have segregated classes, have a diagnostic/assessment requirement for entrance. Nine divisions require both psychological and academic assessments.

The consultation between a classroom teacher and a resource teacher is the most frequently listed pre-referral step (reported by 12 divisions). Other consultations listed are between a classroom teacher and a parent (9 divisions), and classroom and resource teacher and a parent (5 divisions). Consultation, is listed by 6 divisions, but consulting parties are not specified.

Other commonalities reported are that classroom teachers should identify the problem (5 responses) and should try to handle the situation before going further (9 responses). The use of a specific referral form is reported by 4 divisions.

Individualized Education Plans

School divisions indicated the composition of their IEP teams (Table 9). Classroom and resource teachers, school administrators, parents and special education coordinators commonly are present. Clinical staff occur on about two-thirds of the teams. Psychologists and speech/language pathologists may be included in categories for Clinical Staff or Consultants by some divisions. Other potential team members occur on less than half of the divisions' IEP teams.

Table 9. Composition of resource teams to plan IEP's for Level II and III special needs students in Agro-Manitoba

I.E.P. team members	No. divisions	Percent
Classroom teacher	25	96
Resource teacher	25	96
School administrator	24	92
Parent	22	85
Special coordinator	21	81
Clinical staff	17	65
Consultants	12	46
Teacher assistant	11	42
Child	8	31
Counsellor	7	27
Psychologist	7	27
Speech/lang. pathologist	7	27

When asked what formal and informal follow-up and reassessment procedures are in place after implementation of an IEP for Level II and III students, answers were vague. Information received was deemed unreliable and confusing, and is not used in analysis.

IEP's, however, are reviewed periodically, suggesting that follow-up and reassessment do occur. Four divisions report that they review IEP's annually. Five divisions report that reviews are conducted 4 or more times per year, and 16 divisions review IEP's 2 or 3 times per year. Other replies include "after reporting" periods or "as required." One division reviews IEP's weekly.

In 18 divisions the resource teacher is responsible for monitoring and evaluating IEP's. In 9 divisions it is team responsibility, while 5 divisions say the special education coordinator is responsible and another 5 divisions say the classroom teacher is involved. Obviously multiple responsibility occurs in some divisions.

A standard IEP form is used in 15 divisions. Nine divisions report that they use a partially standard form, and two divisions do not use an established form of any kind.

Diagnostic Support Centre (DSC)

When asked how many students they could send to the Diagnostic Support Centre (DSC), 14 divisions responded that they could send only one student per year. Eight divisions sent one or two per year, and one division said they can send two or three per year. One division has not used DSC services in 3 years, one has sent only 1 student in the past 5 years, and one respondent explained that the number varies and is determined regionally.

A total of 28 students were referred from the 26 responding divisions in 1991-1992. There were 18 early years students, 10 middle years students, and none from senior years. Thirteen divisions have students on a waiting list to receive DSC services. Numbers are not available because it was explained during the pilot study that divisions use an "on deck" procedure where the next person to receive services has been identified. Since a division does not expect more than one or two students to receive services per year, making a long list would be a waste of time.

Six divisions had students that stayed at DSC for 2 to 4 weeks, while 5 divisions had students stay 5 to 8 weeks. Ten divisions have home or school based projects that do not require actual use of DSC facilities. The cost of DSC services in 1991-1992 were provided by CCDB and no charges accrue to the divisions.

Divisions report that occasionally some extra costs are incurred. The most frequent extra cost is for substitute fees (11 responses). Other extra costs are for travel and lodging for staff members attending briefing sessions and meetings at DSC (6 responses), and for educational materials and inservice training.

Diverse replies are evident for a question concerning the kind of diagnostic/assessment information received from DSC. Responses occur in 26 different categories. Four divisions say the information in the complete package is too comprehensive to list. There are various general comments saying that the information is very valuable and that the service is excellent. The most common specific areas are reading (5 responses), strategies (4 responses), and learning profiles (3 responses).

School resource teams from 12 divisions actually travelled to Winnipeg. Teams ranged in size from as low as 3 to as high as 11 people. Most teams are comprised of 6-8 people. Conversely, DSC staff travelled to 15 divisions. Seventeen divisions report a specific follow-up procedure. The most frequent response is team meetings. Only one division reports a return trip to Winnipeg for a student, and one division for a team.

A number of problems precipitate accessing DSC services. In 1991-1992, twelve divisions requested services for severe reading problems, ten for learning disabilities, and ten for behaviour problems.

School divisions were asked to suggest changes in DSC services. Overall, comments are positive. Divisions like the site-based model both for individual students and for staff development. Seven divisions suggest that they would like more site-based projects. Four divisions indicate that they appreciate the regional concept. Four divisions suggest no changes, and four others would like to see an increase in DSC services.

School divisions are satisfied with some diagnostic/assessment services. Satisfaction with clinicians in general, or a specific clinical service, is most often mentioned (15 responses). Satisfaction with resource teachers is listed by eight divisions, and three divisions make positive comments about diagnostic/assessment services in general. Several divisions note satisfaction with the "team" approach to diagnostic assessment.

School divisions also suggest areas of diagnostic/assessment services that could be changed. An increase in clinicians or clinician time is the most frequently noted desired change (9 responses). There also is a concern about lack of services to deal with behaviour problems (6 responses). Four divisions suggest that therapy services (PT/OT) should be provided by, or at least billed to, the Department of Health. Five divisions indicate no needed changes.

Diagnostic Support Centre Interview

The Diagnostic Support Centre (DSC) was established eleven years ago in response to needs expressed by rural Manitoba school divisions. Its original role was to be the answer to the "so what do we do now?" question after a school division had exhausted its own resources and a particular student still was not benefiting from her/his educational experiences. The original target population was students with extreme learning problems who came to the Centre for several weeks (usually 4 - 6) for extensive diagnosis and programming. Students then returned to their schools with a complete learning profile and list of strategies that had been successful in the DSC setting.

A staff member at DSC pointed out that there are currently three models or choices a division can use to access DSC services: 1) the original centre-based model, 2) a field-based model, and 3) a consultation model. DSC is flexible and meets with division personnel (special education administrator, principal, classroom teacher, resource teacher) to decide which model is preferred in a given situation. For example, if the team decides that emphasis should be placed on the specific needs of one student, the centre-based approach may be chosen. If emphasis is on teacher training, however, a field-based approach may be the best choice.

Decisions are based on the learning styles and needs of students and classroom teachers. Teachers, as well as students, have different learning styles. Some like the "show me - I'll watch" approach, others like to talk about it, and others prefer the "hands on - I'll try it" approach. Observation is sometimes centre-based, and sometimes field-based. Teachers must know how a child learns and how to structure a classroom for a particular student or group of students. This staff development role has been evolving in addition to the Centre's original diagnostic function. The clientele now includes children with severe behaviour problems as well as those with learning disabilities.

The personnel of DSC include a coordinator who has a psychology background, a psychologist, learning specialists (who must have at least a Master's Degree with emphasis in reading and consultation), a teacher, residence staff, and a secretary. The learning specialists need previous experience either or both as resource teachers and educational consultants because their work requires shifting back and forth between roles. One day they may be teaching individual students and the next day collaborating with classroom teachers and administrators.

Several factors make being a DSC learning specialist a demanding job. Work hours are longer than in a regular school division position, extensive travel is required, and salaries and holidays may not equal what are offered by a school division. The learning specialists at DSC are dedicated to teacher development and see their functions as ways to help students. Some learning specialists who have worked for DSC have moved to learning centres in Winnipeg school divisions.

The Centre is located on the fourth floor of the School for the Deaf but is separate from it. DSC shares some facilities, such as a gymnasium and cafeteria. DSC also uses the services of the audiologist at the School for the Deaf. There are residence facilities for about nine students, and facilities allow "group" observations when needed.

DSC is funded by the Child Care and Development Branch (CCDB). However, individual school divisions pay for all costs that relate to their own staff. Parents must pay for their own and their child's transportation. Meals at DSC are provided by the Centre.

A letter of agreement and commitment to the diagnostic/assessment process is signed by DSC, the school division, and the parents. DSC views development of a team as crucial, because everyone concerned must understand and accept the programs that are developed if they are going to be successful. Older students (Grade 8 and up) may be included in their own team planning.

Sixty-two students from rural school divisions, and eight from Winnipeg and northern divisions received DSC services last year (1991-1992). An effort is made to equalize the opportunity for DSC services according to population in the rural divisions. The Special Education Administrator in a school division contacts their Regional Coordinator who sets priorities on a regional basis. The needs of school divisions are balanced and priorities established within the region. Needs are presented to DSC and an attempt is made to equalize access according to priorities and previous services.

Of last year's 70 projects (individuals or groups of students), 23 were centre-based, 21 were field-based, and 26 were two day consultation meetings with teams. DSC is flexible and the team decides what model will best fit a particular project. Decisions also may be influenced by the time of year. Some seasons are busier than others, although DSC is finding that the demands on their services are becoming consistent throughout the year.

DSC conducts carefully targeted formal testing to check out its own hypotheses, rather than simply repeat what has been done in the school division. They provide strategies to the school divisions for working with individual students or groups of students. For example, it was found preferable to work with students who have severe emotional or behaviour problems in their own schools. It is difficult for ED/BD (emotional or behaviour disorders) students to transfer what they have learned at DSC to their own real life situation. DSC does not provide therapy for these students and prefers to see therapy supports in place before an educational plan is implemented. Therapy services may be provided by Community Services, Mental Health, or private agencies.

A team is established within the school division to provide support for classroom teachers. DSC then supports the division team. Learning specialists follow-up with the team six weeks after the student has returned to the classroom or the program has been implemented. This allows time for some problems to arise and to have been dealt with through the problem solving efforts of the team.

Giving teachers support and allowing the team to have success solving its own problems is a goal of DSC. They want the team to be able to function independently. Follow-up is initiated by DSC at the end of a school year or the beginning of the next one, and is retained for two years. Further services may be provided at the request of the school division.

DSC evaluates their services through both formal and informal measures. The recipients of services are asked to evaluate both process and product. Every two years the process is evaluated through discussions with parents, principals, and other team members. A more formal procedure is used every four to five years through the Special Education Coordinators.

Systematic and continuing internal discussions also occur to determine if or to what extent their organizational goals are being met. The reports of team meetings are sent to DSC learning specialists, which is another way of monitoring how well a particular project is functioning. A future possibility is to establish regional diagnostic centres outside of Winnipeg. Much depends on Manitoba's economy, because this is a government agency that is subject to financial constraints.

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Child Care and Development Branch (CCDB) Information

Decisions about diagnostic services in Agro-Manitoba are made through the Manitoba Education and Training hierarchy as follows:

The following information was gathered during an interview with a senior official of the Child Care and Development Branch.

The Child Care and Development Branch Management Team includes four Regional Coordinators at Interlake/South East (Gimli), Parklands/Southwest (Dauphin), North (Thompson) and South Central (Portage la Prairie). The Management Team includes the Head Consultant for Speech and Language and for Psychology, and the Coordinators for Hearing, Vision, and the Diagnostic Support Centre.

Information needed to make decisions at various levels is gathered through regular meetings. Special Education Administrators from each school division meet with the Management Team Coordinator for their region. As well, there are executive meetings on a regular basis, because one representative from each region is a part of the Special Education Administrators Association of Manitoba (SEAAM) executive. The Management Team Regional Coordinators meet regularly and share information and responsibilities such as low incidence support funding.

CCDB supplies psychological and speech/language services, as well as some reading specialist services, to all Agro-Manitoba divisions. The number of clinical positions is based on provincial funding formulas which, in turn, are based on population. Allocations are made to a region and a regional steering committee (Superintendents, Special Education Administrators, and the Regional Coordinator) decides how to spend their allocations, and how to divide clinical and consultant services among the school divisions within a region. Clinicians and consultants are employed by school divisions, while CCDB acts as an administrator. The steering committee of the region decides what trades are needed to achieve a balance of service within

the region. Each division has been supplied with a vision screening kit and there is a Coordinator of Vision Screening at the CCDB level.

The Department of Health provides some occupational therapy (OT) and physiotherapy (PT), but it is minimal and restricted to more than 100 km outside of large centres such as Winnipeg and Brandon. Any services that take place in a hospital are paid for by the Department of Health. Services performed in a school are billed to the school division on an hourly basis which includes travel time as well as service time.

Most diagnosis is completed by specialists certified by the province of Manitoba. Clinicians certified in Manitoba for the first time are issued two year provisional certificates. At the end of this period, permanent certificates may be issued or the provisional certificate may be extended. Six school clinician certificates are recognized in Manitoba:

1) Occupational Therapists are required to have an approved Bachelor of Occupational Therapy degree and the academic qualifications needed to meet the licensing requirements of the Manitoba Association of Occupational Therapists;

2) Physiotherapists are required to have an approved Bachelor of Physiotherapy degree and the academic qualifications needed to meet the licensing requirements of the Manitoba Association of Physiotherapists;

3) Psychologists must possess an approved Master's degree in School Psychology, or an equivalent discipline;

4) Reading Clinicians are required to hold an approved Master of Education degree which includes appropriate work in clinical reading and related areas. They also must have two years of successful classroom teaching experience in which reading instruction has been an important responsibility, or the equivalent clinical or remedial reading experience, or both;

5) Speech and Hearing Clinicians must have the academic qualifications needed to meet the licensing requirements of the Manitoba Speech and Hearing Association; and

6) Social Workers are required to have an approved Bachelor of Social Work degree.

Speech and language clinician positions are the most difficult to fill. Finding qualified people may be influenced by the time of year and the national market.

A distinct advantage for clinicians who work directly for CCDB is the strong supportive network that exists for them as a member of their regional team. The regional team, including the Regional Coordinator, meets every four to six weeks and shares information and expertise. A clinician hired by a single school division would not have easy access to the support of such a network. If the school division is large enough, clinicians may be able to form a team within their own division.

The greatest change in diagnostic services in the past five years has been the shift from learning disabilities to extreme behaviour problems as the area of most concern to CCDB. There has been an increased need for inter-departmental consultation and collaboration with other agencies such as Child and Family Services. A 24 hour network is being developed to coordinate information from all disciplines because an in-school program can address behavioral problems only during school hours.

Concerns of CCDB

Some concerns were expressed by a senior member of the management staff of CCDB. To meet needs now and in the future the quantity of diagnostic services must be increased. The number of psychologists who are specialists in the area of behaviour problems has to increase through professional development within each region over the next two years. Similarly, there must be increased inter-departmental commitment to collaborate and cooperate between Departments of Education, Health, Child and Family Services, and Justice. Uniform procedures must be established to facilitate inter-departmental cooperation.

Resources have been allocated to establish a Crisis Resource Committee in Metro Winnipeg, and there is intention to extend this model to rural areas in the 1992-1993 school year. Additional local resources are needed within each region. Teams made up of representatives from schools within a school division and/or region could receive training that could be shared with staff from their own schools.

Provincial auditors conduct an internal process audit of CCDB every three to four years. The audit includes the four regions, and interviews are conducted with school and CCDB personnel. As well, CCDB conducts self evaluation through questionnaires. Special Education Administrators channel information about needs and services to Regional Coordinators during their meetings throughout the year.

In the opinion of a senior official, mainstreaming (integration) has been a pedagogical decision by CCDB, rather than a cost saving one. In fact mainstreaming is more expensive. One way to measure effectiveness is to compare today's graduation rate with what it was ten years ago. Over the long term it may be measured by satisfied customers, both parents and educators, who have found that these students can learn, succeed, and complete high school.

To provide a focus for services that are available for special needs children, the province has developed a booklet called *Special Education - Policy and Procedural Guidelines for the Education of Students with Special Needs in the Public School System*. It was published in August of 1989 and is being revised and updated. The booklet outlines the mandate, goals and principles of special education, and programs and services in Manitoba.

There are three levels of funding for special needs students in Manitoba. Level I (block) funding is based on the population of the school division. Level II or III (low incidence) funding is available for students with handicapping conditions who require more individualized instruction (Funding of Schools, 1992/93 School Year). A comprehensive educational needs assessment is used as the basis for determining eligibility for low incidence funding. The application form asks for diagnostic and program information.

AN OVERVIEW OF PROBLEMS AND FACILITIES

Division Level Sources of Diagnostic/Assessment Information

Although all school divisions in Agro-Manitoba have access to psychologists and speech/language pathologists, many share these services. Some divisions would like to see these services increased because large caseloads and long waits for services are problems. An increase in the number of psychologists working in the schools is desired in order to work with both parents and students. Survey respondents desire more services for emotionally disturbed students. One respondent stated that psychiatric services are virtually non-existent for young students.

There also is a need for more speech/language pathologists. These positions are the most difficult to fill because there is a high demand, but short supply of qualified clinicians. One reason for scarcity may be the lack of training programs for speech/language pathologists in Manitoba. The closest schools that offer appropriate programs are in North Dakota and Alberta.

All divisions do not have access to social workers. Many are reviewing their guidance program and believe it should include these services. Information from interviews at the Child Care and Development Branch (CCDB) and the Diagnostic Support Centre (DSC) suggested that behaviour problems are a critical area for consideration.

Reading clinicians are available in only four of the divisions that responded to the survey. The interview at DSC reveals that many of their referrals are for children with reading problems. Also, several Special Education Administrators would like to add reading clinicians to their support teams. A Master's Degree Program with concentration in reading is available in Manitoba, and some reading courses are included in the Master's Degree Programs in Curriculum for Special Education at Brandon University. Additional training, however, would be useful.

Most divisions have access to visually impaired consultants, hearing impaired consultants, occupational therapists, physiotherapists, consultants for the multi-handicapped, and the services of the DSC. Over 75 percent of responding divisions share consultant services.

Occupational and physiotherapy costs are perceived to be medical/health components by some Special Education Administrators. They feel that associated assessment costs should not be billed to school divisions. Similar comments are made about hearing and vision screening.

Community services show the widest variations among the survey respondents. The results are difficult to analyze because of the variety of names for similar services and the number of agencies that provide these services throughout Agro-Manitoba (e.g., Health and Family Services, Mental Health, Health Sciences, Health Nurse, Community Health Services). It was pointed out by several Administrators that community services actually use diagnostic information obtained through the schools rather than vice versa. These groups provide support and advocacy for special needs children and their parents, rather than diagnostic information.

The literature indicates that demand for special education services has increased significantly over the past decade. This is true in Agro-Manitoba and divisions have responded to this need in several ways. Most divisions have increased their number of resource teachers, and have introduced them at middle and senior years. Until recently, resource teachers were hired only for early years.

Increased need also is apparent for guidance. Until recently, guidance counsellors were employed only at senior years and some middle years, depending on the grades within a particular school. It was found that guidance counsellors now are being hired for early years as well.

This is one service that many divisions report as of specific concern. Because of an increasing number of behaviour problems, there is a perceived need for improving and increasing guidance services. This area is mentioned in several Annual Division Action Plans (ADAP) as a target for next year. One survey respondent indicates that identification of behaviour disorders is adequate but programming is a problem. The proposed development of a Master's Degree Program in Guidance and Counselling at Brandon University may help resolve the need for more guidance specialists.

School-based diagnostic services are provided mainly by resource teachers. Alternative assessment practices, such as work samples and classroom observation, are used more by school-based personnel than by division or community-based personnel. This reflects statements in current literature that research and diagnosis have not kept pace with practice, especially in the area of reading. Current researchers suggest that

dramatic changes are needed to move reading diagnosis closer to real life reading situations by including summary writing, metacognitive judgments, question selection, multiple acceptable responses, and prior knowledge. Also reflected is the impact at the division-based and community -based level of other disciplines, such as psychology and social work on educational decisions.

The Referral Process

Four hundred and sixty-three students in 26 divisions are identified and funded as special needs students in 1991-1992. School recommendations are made through the Special Education Administrators and submitted for approval to a team of two of the Regional Coordinators from CCDB.

Eleven of 26 divisions provide segregated special classes. Of these, ten have a diagnostic/assessment requirement for entrance which includes both psychological and academic information. In the 15 divisions that do not have segregated classes, diagnostic information would not be needed for placement decisions.

Testing that results in "a score" or "a label" may be replaced by more instructional diagnosis as a base to plan programs for the regular classroom. Formal test results still are needed for funding decisions for Level II and Level III, which are reviewed each year. Some tests used include WISC-R, WRAT, and Test of Specific Learning Disabilities.

There is a variety of prereferral practices in Agro-Manitoba, no standard prereferral form is used, and the term "prereferral" is not in common usage. Prereferrals could be investigated to determine cost effectiveness and cost benefit relating to reducing time and effort in a formal referral. Prereferral meetings may require fewer people and could save money. Large team meetings take considerable time and are expensive. One division specifically mentioned that it would like to implement a prereferral process, especially at middle and senior years.

IEP planning teams may include any support personnel who have information about a student. Most often listed as team members by divisions are classroom teachers, school administrators, parents, special education administrators, and clinical staff. Provincial guidelines state that IEP's must be reviewed at least annually. Most divisions in Agro-Manitoba report more frequent reviews.

The resource teacher is responsible for monitoring and evaluating IEP's in most divisions. Only nine divisions report that it is a team responsibility. This may occur because the resource teachers are regularly in the school, even if on an itinerant basis, and are the liaison between regular classroom and special education personnel. Bailey (1984) discusses problems resulting from interdisciplinary teams where representatives of different disciplines act as individuals and are not affected by contributions from other team members.

There is no standard IEP form in Manitoba. Fifteen divisions use an established IEP form within their own divisions, and another nine use a partially standardized form. Perusal of 13 IEP forms that were returned with the surveys reveals both similarities and differences. Designing an IEP form for every student allows for creativity and adjustment to individual differences, but a standard form also has advantages. Special education administrators and resource teachers could work together to design a form that would be useful throughout the province. A major advantage would be that a uniform system would allow transfer of special needs students from one school division to another within the province.

Diagnostic Support Centre

Feedback about the quality of DSC services is extremely positive. The only major complaint is that more services are needed. DSC has developed school-based projects which have advantages for some divisions. In the past, parents sometimes rejected the help available at DSC rather than send their child away to Winnipeg for centre-based projects. Respondents report that an advantage of the school-based model is that several students can receive DSC services rather than just one student originally targeted. There also is a large professional development component available to school staff members through working with the learning specialists from DSC. Centre-based projects also are available.

Most divisions do not expect to be able to refer more than one or two students per year to DSC, which serves approximately 70 students per year from all divisions in Agro-Manitoba. Thirteen divisions report having students on a waiting list. Divisions most often request services for severe reading problems, learning disabilities, and behaviour problems.

SUMMARY AND RECOMMENDATIONS

Agro-Manitoba school divisions are providing basic diagnostic/assessment services for their special needs students. However, there are several areas where services could be increased if funds were available.

The cost of special education is increasing and governments are making judgments about who will receive services. Diagnostic information often is used to make funding and placement decisions. At the end of this process, teachers who are responsible for providing special programs may not have received an adequate instructional diagnosis. Teachers, especially reading teachers, are asking for diagnostic information which more closely parallels current reading theory and classroom practice. They want to know what to teach and how to teach it.

This report concentrated on obtaining factual information about current practices rather than about attitudes or satisfaction with these practices. Data were collected at a level removed from the classroom teacher. Further studies should examine the satisfaction of regular classroom teachers with current practices in Agro-Manitoba. Most Special Education Administrators are positive in regard to their diagnostic/assessment services, especially about clinicians, resource teachers, and a team approach. It would be of value to investigate if satisfaction is shared by regular classroom teachers. Ysseldyke (1986) reported that classroom teachers are the least satisfied participants at IEP team meetings. Classroom teachers, of course, are responsible for delivering a special program, but many team meetings are more concerned with placement or funding decisions rather than with instructional diagnosis.

Several Special Education Administrators report a need for increased clinical services, especially in the area of behaviour problems. This area was discussed during interviews with CCDB and DSC staff. Behaviour problems are beginning to replace learning disabilities as the area of greatest concern. These problems also were apparent in an examination of ADAP's. Several divisions are planning a complete restructuring of their guidance services, which include social workers, because of an increase in severe behaviour problems. Respondents from one region, composed of five school divisions, indicate that they have pooled their resources and established their own "behavioral centre" as a regional cooperative effort.

The following recommendations are based on consideration of information presented.

1. There are several ways of expanding DSC services to Agro-Manitoba. DSC could become a professional development training resource through either a centre-based model or a field-based model.

2. Another possibility is to establish regional centres outside of Winnipeg, either under DSC guidance or based on the DSC model.

3. A third possibility is a cooperative venture between DSC and the Faculties of Education at Brandon University and the University of Manitoba. The practical experience of DSC staff could be combined with course work so that teachers receive appropriate training as well as university credits. Courses could be offered at off-campus sites for groups of teachers in rural Manitoba.

4. A newsletter or conference about DSC projects could be placed on MINET (an interactive computer network utilized across Manitoba and available to all educational agencies) and would not be expensive. This could be a vehicle for sharing ideas, programs, and successes with special educators throughout rural Manitoba.

5. Many experts advocate use of both formal and informal techniques in assessment of special needs. An examination of survey results and ADAP's suggests that this is standard practice in Agro-Manitoba. Some divisions and some educators in particular divisions put more or less emphasis on one or the other of the techniques. Some divisions strongly prefer alternative assessment, and seem to be aware of recent theory and practice.

6. Most authors stress the use of a team approach in assessment and decision making. In Agro-Manitoba, teams are part of these processes at every level from individual schools to CCDB. In theory, the purpose of a team approach is to ensure that all necessary information is contributed and acted upon in the best interest of the student. Ysseldyke (1986), however, strongly questions the efficacy of the team approach in practice. This would be an interesting area for further research in Agro-Manitoba.

7. Members of teams may vary according to the needs of the student, but usually include school support personnel. Many divisions in Agro-Manitoba share support personnel with other divisions or agencies. This is one way to provide at least a minimum service level, but survey results and ADAP's show that divisions would like to see an increase in these services.

   This research explored satisfaction with these services at an administrative level. Further research into satisfaction with diagnostic services should be carried out with the resource teachers and classroom teachers who are responsible for actually teaching special needs students.

8. McLoughlin and Lewis (1990) include the design of an Individual Assessment Program (IAP) before assessment begins. Data from the survey shows clearly that this is not standard practice in Agro-Manitoba. A few Special Education Administrators did express a desire to initiate a prereferral process in their division. If this step is implemented, the team at IAP (assessment) meetings might be large, but the IEP (education) team could be much smaller. It would not be cost-effective to have large teams at both meetings.

9. The necessity of labelling Manitoba students as mentally retarded, learning disabled, etc. has been partly reduced by combining categories into levels (block funding, Level II, Level III) based on the amount of assistance that a special student requires. The traditional labels are used to make funding decisions, but not necessarily for programming decisions.

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APPENDIX A

Glossary of Acronyms

1. ADAP - Annual Division Action Plan
2. BD - Behaviour Disorder
3. CCDB - Child Care and Development Branch
4. DSC - Diagnostic Support Centre
5. ED - Emotionally Disturbed
6. EMR - Educable Mentally Retarded
7. IAP - Individualized Assessment Plan
8. IEP - Individualized Education Plan
9. IRI - Informal Reading Inventories
10. LD - Learning Disabilities
11. LDAM - Learning Disabilities Association of Manitoba
12. MCT - Minimum Competency Testing
13. QAR - Question-Answer Relationship
14. RDI - Rural Development Institute
15. SEAAM - Special Education Administrators of Manitoba
16. WISC-R - Wechsler Intelligence Scale for Children, Revised
17. WRAT - Wide Range Achievement Test

APPENDIX B

Survey Questionnaire for Rural School Divisions

Part IA Sources of Diagnostic/Assessment Information

1. Check the Clinical Services which are sources of diagnostic/assessment information in your school division:

Psychologist	Speech/Language Pathologist
Social Worker	Native Education Counsellor
Others (please list):	

If any of these services are shared with other school divisions, please specify.

2. Check the Consultant Services which are sources of diagnostic/assessment information in your school division.

_____ Visually impaired consultant
_____ Hearing impaired consultant
_____ Occupational therapist
_____ Physiotherapist
_____ Multi Handicapped Consultant
_____ Diagnostic Support Centre Services
Others? (please list)

If any of these services are shared with other school divisions, please specify.

Are these services provided by the Provincial Government?

3. Check the Community Services which are sources of diagnostic/assessment information in your school division:

_____ Learning Disabilities Association of Manitoba
_____ Society for Manitobans with Disabilities (ex. Rural Preschool Program)
_____ Child and Family Services
_____ Manitoba Health and Family Services (ex. Vocational Rehabilitation Services)
_____ Brandon Mental Health Centre (ex. Child and Adolescent Outpatient Service)
_____ Child Development Clinic (Health Sciences Centre-Wpg.)
_____ Association for Community Living
_____ Arm Industries Incorporated
Others: Please specify.

4. Has your school division implemented programs or procedures to improve diagnostic/assessment services for special needs students (block funded, Level II, Level III) during the last five years? Please describe. (ex. resource teachers at middle years level)

Part 1B

5. What school based diagnostic/assessment services are used in your division:

   At early years level? Please list. (ex. resource teachers)

   At middle years level?

   At senior years level?

What diagnostic/assessment services do they provide? (ex. achievement tests)

Are any of the above services shared with other school divisions? Please specify.

Are any of the above services provided by other agencies? (ex. Health)

6. What division based diagnostic/assessment services are used in your division: (ex. psychologists)

   At early years level?

   At middle years level?

   At senior years level?

What diagnostic/assessment services do they provide? (ex. intelligence tests)

If any of the above services are shared with other school divisions, please specify.

If any of the above services are provided by other agencies, please specify.

7. What community based diagnostic/assessment services are used in your division:

At early years level?

At middle years level?

At senior years level?

What diagnostic/assessment services do they provide?

If any of the above services are shared with other school divisions, please specify.

Are any of the above services provided by other agencies?

Part II Referral Process

8. How many identified and funded special needs students were there in your school division during 1991-1992?

Level II _____

Level III _____

Special funding _____

9. What does your school division purchase with its block funding?

10. Does your school division provide segregated special classes? _____

Please provide details:

Class name	# of classes	# of Students	Age/grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

11. Is there a diagnostic/assessment requirement for entrance into these classes? _____

Please specify.

12. What steps are taken prior to a student's referral to a resource teacher in your school division?

13. Who may be included in a school resource team to plan IEP's (Individual Education Plan) for Level II and III students? Please list titles. (ex. school administrator, resource teacher, etc.)

14. What follow-up and reassessment procedures are in place after an IEP for Level II and III students has been implemented? (both formal and informal)

15. How often are these IEP's reviewed?

16. Who monitors and evaluates IEP's?

17. Does your school division use a standard IEP form? _____

Part III Diagnostic Support Centre (D.S.C.)

18. How many students from your school division (s.d.) are you allowed to refer to D.S.C. per school year? _____

19. How many students were referred to D.S.C. from your division during 1991-1992? _____

K - 4 _____
5 - 8 _____
9 - 12 _____

20. Do you have students from your s.d. who are on a waiting list to receive services from D.S.C? _____

21. How many weeks did each student spend at D.S.C.?

Student 1 _____ Student 2 _____ Student 3 _____ Student 4 _____

22. What was the cost of D.S.C. services to your division during 1991-1992?

23. Were there additional costs? (ex. substitute fees)

24. What kind of diagnostic/assessment information was given to your s.d. by D.S.C.?

25. Did the school resource team travel to Winnipeg? _____ How many people were in the team? _____

26. Did D.S.C. staff travel to your school division? _____

27. What follow-up or reassessment procedure was implemented?

28. Was a return trip to Winnipeg needed for the student? _____ or school team? _____

29. Do you request D.S.C. services for particular kinds of problems? (ex. severe reading difficulties, behaviour problems, etc.)

30. Are there any changes you would like to see in D.S.C. services for your division?

Part IV Overview

31. Are there any areas of diagnostic/assessment services in your s.d. with which you are very satisfied? Please specify.

32. Are there any areas of diagnostic/assessment services in your s.d. where you would like to make changes? Please specify.

The following documents from your school division would give me valuable information for my research.

1. Annual Division Action Plan
2. Resource Teacher Referral Form
3. IEP (Individual Education Plan) Form. (or equivalent)

I would appreciate your forwarding copies of these documents by the end of June.

APPENDIX C

Child Care and Development Branch (CCDB) Interview Schedule

1. Who (titles) plans for and makes decisions about diagnostic services in rural Manitoba? (hierarchy)

2. How is information gathered at various levels to make these decisions?

3. What diagnostic services are provided by CCDB to rural divisions? How are they allocated? (i.e. population, shared among divisions) How are they funded? (CCDB, division, municipality)

4. Are any diagnostic services provided by other government agencies such as Health? How are costs shared?

5. Are there standard qualifications for certification as a diagnostician in Manitoba? Are they rigidly adhered to? Is there a scarcity of qualified personnel? Can rural divisions attract them and afford them?

6. What new developments have there been in diagnostic services in the past 5 years?

7. What are future trends?

8. Has mainstreaming been a philosophical and/or a cost saving decision?

9. Is there any way of estimating if it is cost beneficial or cost effective? (benefit to $ ratio)

10. Are any federal or provincial laws or guidelines used to determine eligibility for special ed. services?

11. Explain how diagnostic information is used to determine the different levels of funding? (block, Level II, Level III)

12. What is the history of DSC?

13. What is its present role?

14. How is it funded?

15. What changes have occurred recently? (different models)

16. What is planned for the future?

APPENDIX D

Diagnostic Support Centre Interview Schedule

1. History: When was DSC established?
   Why? (Has a needs assessment ever been done?)
   Are there any documents which record DSC's history?

2. Have there been any recent changes? What different models are used?

3. Present role:

   - personnel (qualifications, experience, scarcity)
   - facilities?
   - funding?
   - who receives services? (numbers and home residences by S.D. for last five years)
   - who decides models used?
   - what kind of diagnostic information is given to school divisions? how are numbers of students per division determined?
   - what follow-ups and reassessments are recommended?

4. How does DSC evaluate their own services?

5. What will the needs of DSC be in the future?